FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035352

Facility Name: Rosewood Care Center of Peoria

Address: 1500 West Northmoor Road (Number) Peoria (City) 61614 (Zip Code)

County: Peoria

Telephone Number: (309) 637-2000 **Fax #** ( )

IDPA ID Number: 431446786001

Date of Initial License for Current Owners: 6/12/1989

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2004 to 6/30/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) Accountant's Compilation Report Attached (Date)

(Print Name and Title) Cindy A. Tefteller

(Firm Name & Address) C.J. Schlosser & Company, 233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			12,230	12,230	8
9	SNF/PED					9
10	ICF	3,349	14,918		18,267	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,349	14,918	12,230	30,497	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.63%

D. How many bed-hold days during this year were paid by the Department? 7 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/12/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/12/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 12,230

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2005 Fiscal Year: 6/30/2005

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	192,856	18,521	8,529	219,906		219,906		219,906			1
2	Food Purchase		148,844		148,844		148,844	(5,916)	142,928			2
3	Housekeeping	138,697	35,039		173,736		173,736		173,736			3
4	Laundry	39,542	20,233		59,775		59,775		59,775			4
5	Heat and Other Utilities			115,594	115,594		115,594	5	115,599			5
6	Maintenance	5,151	8,434	80,854	94,439		94,439	23,199	117,638			6
7	Other (specify):* Sanitation			9,145	9,145		9,145		9,145			7
8	**TOTAL General Services**	376,246	231,071	214,122	821,439		821,439	17,288	838,727			8
	B. Health Care and Programs											
9	Medical Director			31,574	31,574		31,574		31,574			9
10	Nursing and Medical Records	1,479,049	166,280	435,669	2,080,998		2,080,998		2,080,998			10
10a	Therapy	60,105	5,690	555,086	620,881		620,881	(28,206)	592,675			10a
11	Activities	52,759	3,542	2,400	58,701		58,701		58,701			11
12	Social Services	31,642	120	2,400	34,162		34,162		34,162			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,623,555	175,632	1,027,129	2,826,316		2,826,316	(28,206)	2,798,110			16
	C. General Administration											
17	Administrative			597,000	597,000		597,000	(452,887)	144,113			17
18	Directors Fees											18
19	Professional Services			3,885	3,885		3,885	33,247	37,132			19
20	Dues, Fees, Subscriptions & Promotions			26,717	26,717		26,717	(7,036)	19,681			20
21	Clerical & General Office Expenses	149,394	37,679	14,333	201,406		201,406	135,892	337,298			21
22	Employee Benefits & Payroll Taxes			269,975	269,975		269,975	26,865	296,840			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,296	1,296		1,296		1,296			24
25	Other Admin. Staff Transportation			5,134	5,134		5,134	14,786	19,920			25
26	Insurance-Prop.Liab.Malpractice			62,877	62,877		62,877	16,367	79,244			26
27	Other (specify):*											27
28	**TOTAL General Administration**	149,394	37,679	981,217	1,168,290		1,168,290	(232,766)	935,524			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,149,195	444,382	2,222,468	4,816,045		4,816,045	(243,684)	4,572,361			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center of Peoria #0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			9,736	9,736		9,736	161,006	170,742			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							744,771	744,771			32
33	Real Estate Taxes			66,275	66,275		66,275		66,275			33
34	Rent-Facility & Grounds			1,224,409	1,224,409		1,224,409	(1,212,484)	11,925			34
35	Rent-Equipment & Vehicles			20,140	20,140		20,140		20,140			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,320,560	1,320,560		1,320,560	(306,707)	1,013,853			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		249,605	37,447	287,052		287,052		287,052			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		249,605	103,147	352,752		352,752		352,752			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,149,195	693,987	3,646,175	6,489,357		6,489,357	(550,391)	5,938,966			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,556)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,979)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(360)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(989)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,454)	20		28
29	Other-Attach Schedule Marketing Salary	(64,065)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (86,403)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(463,988)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (463,988)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (550,391)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rosewood Care Center of Peoria

ID# 0035352

Report Period Beginning: 7/1/2004

Ending: 6/30/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (64,065)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(64,065)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,916)	0	0	0	0	0	0	0	0	0	0	(5,916)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	5	0	0	0	0	0	0	0	0	5	5
6	Maintenance	0	0	23,199	0	0	0	0	0	0	0	0	23,199	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,916)	0	23,204	0	0	0	0	0	0	0	0	17,288	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(28,206)	0	0	0	0	0	0	0	0	0	(28,206)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(28,206)	0	0	0	0	0	0	0	0	0	(28,206)	16
	C. General Administration													
17	Administrative	0	(597,000)	144,113	0	0	0	0	0	0	0	0	(452,887)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	33,247	0	0	0	0	0	0	0	0	33,247	19
20	Fees, Subscriptions & Promotions	(7,443)	0	407	0	0	0	0	0	0	0	0	(7,036)	20
21	Clerical & General Office Expenses	(64,065)	0	199,957	0	0	0	0	0	0	0	0	135,892	21
22	Employee Benefits & Payroll Taxes	0	0	26,865	0	0	0	0	0	0	0	0	26,865	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	14,786	0	0	0	0	0	0	0	0	14,786	25
26	Insurance-Prop.Liab.Malpractice	0	6,659	9,708	0	0	0	0	0	0	0	0	16,367	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(71,508)	(590,341)	429,083	0	0	0	0	0	0	0	0	(232,766)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,424)	(618,547)	452,287	0	0	0	0	0	0	0	0	(243,684)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rosewood Care Center of Peoria** **#** **0035352** **Report Period Beginning:** **7/1/2004** **Ending:** **6/30/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	142,843	18,163	0	0	0	0	0	0	0	0	161,006	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,979)	753,750	0	0	0	0	0	0	0	0	0	744,771	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,224,409)	11,925	0	0	0	0	0	0	0	0	(1,212,484)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,979)	(327,816)	30,088	0	0	0	0	0	0	0	0	(306,707)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(86,403)	(946,363)	482,375	0	0	0	0	0	0	0	0	(550,391)	45

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Management Fee	$ 597,000	HSM Management Services, Inc.	100.00%	$	$ (597,000)	1
2	V									2
3	V		10a	Therapy	555,086	Rosewood Therapy Services, Inc.	0.00%	526,880	(28,206)	3
4	V									4
5	V		34	Rent	1,224,409	Peoria Real Estate, Inc.	0.00%		(1,224,409)	5
6	V		30	Depreciation		Peoria Real Estate, Inc.	0.00%	142,843	142,843	6
7	V		32	Interest		Peoria Real Estate, Inc.	0.00%	753,750	753,750	7
8	V		26	Property Insurance		Peoria Real Estate, Inc.	0.00%	6,659	6,659	8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 2,376,495			$ 1,430,132	$ * (946,363)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	See Schedule VIII	$	HSM Management Services, Inc.	100.00%	$ 144,113	$ 144,113	15
16	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	199,957	199,957	16
17	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	26,865	26,865	17
18	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	14,786	14,786	18
19	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	18,163	18,163	19
20	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	11,925	11,925	20
21	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	33,247	33,247	21
22	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	9,708	9,708	22
23	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	23,199	23,199	23
24	V	5	See Schedule VIII		HSM Management Services, Inc.	100.00%	5	5	24
25	V	20	See Schedule VIII		HSM Management Services, Inc.	100.00%	407	407	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 482,375	$ * 482,375	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Vander Maten	President	Management	75.00%	1,148,631	2	5.91%	Salary	$ 72,099	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	472,635	2	5.91%	Salary	29,667	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 101,766		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	87,014,347	18	$ 1,723,032	$ 1,723,032	5,139,261	$ 101,766	1
2	21	Salaries - Others	Total Cost	87,014,347	18	2,976,309	2,976,309	5,139,261	175,787	2
3	22	Payroll Taxes	Total Cost	87,014,347	18	298,975		5,139,261	17,658	3
4	22	Employee Benefits	Total Cost	87,014,347	18	103,243		5,139,261	6,098	4
5	25	Travel	Total Cost	87,014,347	18	249,076		5,139,261	14,711	5
6	30	Depreciation	Total Cost	87,014,347	18	307,518		5,139,261	18,163	6
7	34	Building Rent	Total Cost	87,014,347	18	201,898		5,139,261	11,925	7
8	19	Professional Services	Total Cost	87,014,347	18	562,909		5,139,261	33,247	8
9	21	Telephone	Total Cost	87,014,347	18	173,318		5,139,261	10,237	9
10	26	Insurance	Total Cost	87,014,347	18	164,374		5,139,261	9,708	10
11	21	Taxes, Licenses, Ofc Sup	Total Cost	87,014,347	18	235,903		5,139,261	13,933	11
12	6	Maintenance	Total Cost	87,014,347	18	157,822		5,139,261	9,321	12
13	5	Heat & Other Utilities	Total Cost	87,014,347	18	77		5,139,261	5	13
14	20	Dues & Subscriptions	Total Cost	87,014,347	18	6,896		5,139,261	407	14
15	17	Direct - Admin	Direct Cost	1	1	42,347	42,347	1	42,347	15
16	17	Direct - Admin	Direct Cost	17	17	1,113,599	1,113,599	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	3,109		1	3,109	17
18	22	Direct - Payroll Taxes	Direct Cost	17	17	79,613		0	0	18
19	30	Direct - Depreciation	Direct Cost	1	0	0		1	0	19
20	30	Direct - Depreciation	Direct Cost	2	2	1,050		0	0	20
21	25	Direct - Travel	Direct Cost	1	1	75		1	75	21
22	25	Direct - Travel	Direct Cost	6	6	973		0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	13,878		1	13,878	23
24	6	Direct - Maintenance	Direct Cost	14	14	217,533		0	0	24
25	TOTALS					$ 8,633,527	$ 5,855,287		$ 482,375	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	$72,980.00	10/26/99	$ 8,775,000	$ 0	11/2009	8.89%	$ 744,506	1
2	Bank of America		X	Refinance Mortgage	Varies	6/30/05	12,000,000	12,000,000	6/2008	LIBOR+1.4%	0	2
3	Amortization of Loan Fees										82,641	3
4	Less: Related Party Interest Offset										(73,397)	4
5	Less: Interest Income Offset										(8,979)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$72,980.00		$ 20,775,000	$ 12,000,000			$ 744,771	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,775,000	$ 12,000,000			$ 744,771	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 0** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Rosewood Care Center of Peoria **#** 0035352 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 77,745	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 75,570	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,175)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 74,907	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 6,457 **For** 2003 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (6,457)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 66,275	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	74,207	8
	2001	69,725	9
	2002	72,217	10
	2003	76,975	11
	2004	74,165	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2003 Payment = $38,487
2004 Payment = $37,083
Accrual = Balance of 2004 tax bill ($37,083) + 1/2 of estimated 2005 tax bill ($37,824)

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0035352

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-326-009	1500 W. Northmoor Road	$ 74,165.00	$ 74,165.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,165.00	$ 74,165.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,500 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	7.343 Acres	1989	$ 212,793	1
2					2
3	TOTALS	7.343 Acres		$ 212,793	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	$ 2,829,643	$	15-25	$ 112,520	$ 112,520	$ 2,029,159	4
5				1991	4,140		25	166	166	2,309	5
6				1992	7,309		5			7,309	6
7				1992	2,756		10			2,756	7
8											8
	Improvement Type**										
9	Legal, Arch, Eng, Contractor Fees			1989	32,140		25	1,285	1,285	20,682	9
10	Capitalized Interest			1989	15,100		25	604	604	9,714	10
11	Site Improvement, Sewers, Landscaping, Traffic Study			1989	306,686		15-25	10,840	10,840	229,183	11
12	Entry Concrete Slab			1990	6,197		20	310	310	4,420	12
13	Irrigation System			1993	10,125		25	405	405	4,894	13
14	Parking Lot Expansion			1994	3,475		25	139	139	1,506	14
15	Parking Lot Expansion			1995	56,648		25	2,266	2,266	21,716	15
16	Irrigation System			1995	2,029		25	81	81	776	16
17	Parking Lot			1997	39,664		25	1,587	1,587	13,489	17
18	Walk-in Cooler			1989	5,770		10			5,770	18
19	Sinks			1989	3,744		10			3,744	19
20	Exhaust Hood			1989	4,620		10			4,620	20
21	Fire Suppression System			1989	1,271		10			1,271	21
22	Generator			1989	14,937		10			14,937	22
23	Intercom System			1989	650		10			650	23
24	Facility Signs			1989	3,234		10			3,234	24
25	Baseboard Heaters			1989	672		10			672	25
26	Carpet			1989	7,664		10			7,664	26
27	Cubicle Track			1989	6,294		10			6,294	27
28	Sign			1991	3,733		10			3,733	28
29	Monument Sign			1992	1,737		10			1,737	29
30	Ceramic Sink			1994	2,011		10	68	68	2,011	30
31	Parking Lot Sealing & Striping			2004	21,277		25	851	851	1,347	31
32	Backflow Preventers			2005	6,600		10	220	220	220	32
33											33
34	Leasehold Improvements - Facility										34
35	Pave Driveway			1994	2,822		7			2,822	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Painting/Baseboards/Carpeting	1995	$ 33,169	$	7	$	$	$ 33,169	37
38	Cabinet Work	1995	1,868		7			1,868	38
39	Widen Activity Door	1996	2,659		7			2,659	39
40	Painting/Baseboards/Carpeting	1996	3,600		7			3,600	40
41	Carpeting/Undercounter Refig/Cabinets/Plants	1998	16,121	2,303	7	2,303		15,354	41
42	Wallpaper/Mini Blinds	1999	12,830	1,833	7	1,833		11,570	42
43	Ceiling Tiles	2000	991	142	7	142		671	43
44	Computer Cabling	2000	2,392	342	7	342		1,567	44
45	Door Alarm System	2000	3,143	449	7	449		2,170	45
46	Computer Receptacles	2001	214	31	7	31		138	46
47	Seal Parking Lot	2002	6,330	904	7	904		3,541	47
48	Painting	2003	3,167	452	7	452		1,093	48
49	Painting/Wallpaper	2004	6,220	889	7	889		963	49
50	Wallcovering	2004	4,164	595	7	595		595	50
51									51
52									52
53									53
54									54
55									55
56	Leasehold Improvements - Management Company:							452	56
57	Office Construction/Improvements	1995	452		5			41	57
58	Office Design	1995	41		5			96	58
59	Office Shelving	1996	96		4			427	59
60	Office Expansion	1996	427		4			1,143	60
61	Office Expansion	1997	1,143		3			645	61
62	Office Expansion	1998	645		3			318	62
63	Office Addition	1999	318		3			159	63
64	Door Locks	1999	159		3				64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,503,097	$ 7,940		$ 139,282	$ 131,342	$ 2,490,878	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 182,352	$ 1,796	$ 22,206	$ 20,410	5-10 Yrs	$ 111,484	71
72	Current Year Purchases	14,919		864	864	5-10 Yrs	864	72
73	Fully Depreciated Assets	414,611					414,611	73
74								74
75	TOTALS	$ 611,882	$ 1,796	$ 23,070	$ 21,274		$ 526,959	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	$ 37,748	$	$ 8,390	$ 8,390	4	$ 17,295	76
77										77
78										78
79										79
80	TOTALS			$ 37,748	$	$ 8,390	$ 8,390		$ 17,295	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,365,520	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,736	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 170,742	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 161,006	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,035,132	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

N/A - ONLY HIRE CERTIFIED AIDES
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs	$	24,842	$	235,996	$	24,842	$ 235,996	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,281		34,378		1,281	34,378	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-8	hrs		23,218		256,506	5,690	23,218	262,196	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-8	# of prescrpts					232,354		232,354	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Ambulance, Lab, X-Ray and Other (specify): Enterals	39-8					37,447	17,251		54,698	13
14	TOTAL			$	49,341	$	564,327	$ 255,295	49,341	$ 819,622	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,747	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	796,345		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,684		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 835,210	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	112,269		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(90,067)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 22,202	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 857,412	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 304,015	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,142		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,906		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,907		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	46,200		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 562,170	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 562,170	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 295,242	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 857,412	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 286,895	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 286,895	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	205,347	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(197,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 8,347	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 295,242	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,117,126	1
2	Discounts and Allowances for all Levels	(2,581,992)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,535,134	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,269,834	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,269,834	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,800	13
14	Non-Patient Meals	5,556	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,356	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,979	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,979	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	301	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 301	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,824,604	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	821,439	31
32	Health Care	2,826,316	32
33	General Administration	1,168,290	33
	B. Capital Expense		
34	Ownership	1,320,560	34
	C. Ancillary Expense		
35	Special Cost Centers	287,052	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,489,357	40
41	**Income before Income Taxes (line 30 minus line 40)****	335,247	41
42	**Income Taxes**	(129,900)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 205,347	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	986	1,034	$ 29,821	$ 28.84	1
2	Assistant Director of Nursing	1,572	1,648	44,763	27.16	2
3	Registered Nurses	16,259	17,045	419,352	24.60	3
4	Licensed Practical Nurses	9,273	9,721	200,305	20.61	4
5	CNAs & Orderlies	61,556	64,532	720,570	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,296	3,455	60,105	17.40	8
9	Activity Director					9
10	Activity Assistants	4,931	5,169	52,759	10.21	10
11	Social Service Workers	3,113	3,263	31,642	9.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,503	21,494	192,856	8.97	15
16	Dishwashers					16
17	Maintenance Workers	379	398	5,151	12.94	17
18	Housekeepers	15,526	16,277	138,697	8.52	18
19	Laundry	4,740	4,969	39,542	7.96	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,979	12,558	149,394	11.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,513	4,731	64,238	13.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,626	166,294	$ 2,149,195 *	$ 12.92	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	375	$ 8,529	1-3	35
36	Medical Director	Contract	31,574	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	100	2,400	11-3	44
45	Social Service Consultant	100	2,400	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	575	$ 44,903		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,849	$ 105,590	10-3	50
51	Licensed Practical Nurses	9,825	330,079	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	12,674	$ 435,669		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Schmidgall	Administrator	0.00%	$ 15,431
Janice Kindred	Administrator	0.00%	26,916
Total Direct Administrator Cost from HSM Mgmt - Line 17, col 7			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 42,347

B. Administrative - Other

Description	Amount
Management Fees	$ 597,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 597,000

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 3,835
	Legal Fees	50
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 3,885

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,700
Unemployment Compensation Insurance	53,614
FICA Taxes	163,810
Employee Health Insurance	3,507
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Manage Company Allocations	26,865
Employee Physicals	2,233
Employee Uniforms	359
Employee Relations	2,132
Tuition Reimbursement	1,620
TOTAL (agree to Schedule V, line 22, col.8)	$ 296,840

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,896
Health Care Worker Background Check	
(Indicate # of checks performed 135)	1,618
Promotional Advertising	4,442
Misc. Dues/Subscriptions	6,760
Management Company Allocation	407
Less: Public Relations Expense	(121)
Non-allowable advertising	(867)
Yellow page advertising	(3,454)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,681

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,296
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,296

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center of Peoria # 0035352 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria **#** 0035352 **Report Period Beginning:** 7/1/2004 **Ending:** 6/30/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $6,869**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **60,929** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,556**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER OF PEORIA, INC.
IDPH ID #0035352
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2005

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	$ 5,134
	$ 5,134

**ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS SUBMITTED WHICH WERE LESS THAN $250.00 EACH

ROSEWOOD CARE CENTER OF PEORIA, INC.
IDPH ID #0035352
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2005

RELATED NURSING HOME:	CITY:
ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:	TYPE OF BUSINESS:
HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
PEORIA REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY